Request to Amend or Correct Protected Health Information

Date: _____
Name: _____

I. Request for Amendment or Correction

I hereby request to amend protected health information ("PHI") about me in a "designated record set" held by the Kentucky Employees Health Plan (the "Plan") in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

> A *"designated record set"* is a group of records maintained by or for the Plan including enrollment, payment, claims adjudication and health plan case or medical management record systems; or records used by or for the Plan to make decisions about individuals. The term "record" means any item, collection or grouping of information that includes protected health information that is maintained, collected, used or disseminated by or for the Plan.

Describe Amendment Requested:_____
_____
_____

Reason for Requested Amendment:_____
_____
_____

I understand that if the protected health information was not created by the Plan, the Plan is not required to honor my request. For example, if the information I wish to amend is in a medical report created by my health care provider, I must ask the provider to amend the report. I also understand that if the information is not available for my inspection, is not part of the Plan's designated record set or is already accurate and complete, I cannot amend the information.

II. Other Important Information

I understand that the Plan will respond to my request within 60 days. If the Plan is unable to take action within the applicable time period, the Plan may extend the time for such action by 30 days, provided the Plan, within the original 60-day time period, gives me a written statement of the reasons for the delay and the date by which it will complete its action on the request.
If the Plan accepts the requested amendment, the Plan shall make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise provided a link to the location of the amendment. The Plan shall timely inform me that the amendment is accepted and obtain my identification of relevant persons with which the amendment needs to be shared as provided in HIPAA. The Plan shall make reasonable efforts to inform (a) persons identified by me as having received my PHI and needing amendment,
and (b) persons, including business associates (as defined in HIPAA) of the Plan, that the Plan knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information.

If the request is denied in whole or in part, the Plan will provide me with a written denial.

III. Signature of Member or Member's Representative

_____ _____

Signature of member or member's representative **Date**

(Form MUST be completed before signing.)

Printed name of the member's personal representative:

_____

Relationship to the member, including authority for status as representative:

_____

_____

Signature

_____

Printed

Department of Employee Insurance
501 High Street, 2nd Floor
Frankfort, Kentucky 40601
(502) 564-6534